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### 2.1 Jack

Jack, at 32 years old, just had his first panic attack. He had just returned to work from his lunch break and wasn't thinking of anything negative. Suddenly, he started to sweat and feel his heart pounding. Thinking he was having a heart attack, his coworkers rushed him to the emergency room. He felt he couldn't breathe. It was terrifying. The doctor soon reassured Jack that his heart was fine, gave him benzodiazepine sedatives, which he should take every 6 h to calm his anxiety, and recommended that he make an appointment to see a therapist.

During Jack's first therapy session, he explains that his panic came for no apparent reason. In fact, his life has been going well. He has a good job as a cable installer and, only a few days ago, was offered a promotion. He has a 2-year-old child, and his wife told him last week that she is pregnant with a second one. Taking a history, there isn't much that is remarkable. Jack was the oldest of four. Life wasn't so easy for his parents, but they did their best. His father had a small appliance repair business and worked long hours. Coming home late and exhausted, he sometimes drank too much. Jack's mother shouldered the burdens of the household. For extra money she watched neighbors' children while Jack took care of his younger siblings. According to Jack, his early life was fine. He was proud to take care of the younger ones and still managed to be an average student. He played sports in high school and was glad to find a good job soon after his graduation. When he met Jane in a bar, she admired his sense of responsibility, and he liked her positive attitude.

With all these good things happening, Jack is baffled about why he might develop a psychological problem at this point in his life. He prides himself on being a good provider and feels he can handle whatever challenges come his way. Not one to complain or ask for help, he was reluctant to see a therapist. Therapy is for weak people, like his sister, who leans on others and takes pills. If he were at all like her, he would hate himself. He would like to limit any therapy to one visit and go on his way.

## 2.2 Dividing the Problem

For a therapist, Jack's case presents two problems. The first is the panic attack itself, which we want to keep from becoming a repeating pattern. The second problem could be thought of as a strength, his self-sufficiency. This reluctance to accept help has been a positive feature of his personality but now creates a serious challenge to working with him. We'll call these two troublesome issues *modules* because dividing Jack's problems into chunks will reduce their complexity and point the way to what to do next. Going forward, we will refer to the two modules as Jack's personality and Jack's panic attacks.

## 2.3 Jack's Personality

The first module we will have to deal with is actually Jack's reluctance to engage in treatment. If we fail to make progress with that, then there will not be any treatment. His values, and his strengths, are heavily weighted in the direction of being self-reliant. Not only does Jack not believe in therapy, he would feel genuinely ashamed if he saw himself in any way like his sister. If we start by telling him he needs more therapy, he will run the other way.

From this information, we can conceptualize Jack's personality as a problem module. Let's try to form an educated guess as to why Jack feels so strongly about handling things himself. Jack may have learned the value of self-sufficiency from his parents, but he seems to make it the center of his being. Could we understand his value system as originally a way of coping with some difficulty? He says that his early life was "fine," but the facts don't entirely fit. It sounds as if being the first child in his family was really quite hard. He had to grow up quickly, and the level of support sounds minimal. If he had complained, he would likely have been rebuffed. A few questions confirm that asking for attention was not well received by his father in particular. By placing emphasis on self-reliance, he aligned himself with his father's values. Internalizing these values created a shame barrier against any temptation to seek support. Now even anticipation of the shame associated with neediness stands as a deterrent to seeking help, while doing without results in an internal feelings of pride. Today, Jack's values have become an unhealthy block to receiving the treatment he needs.

Let's look more generally at how internalizing a value system can start out as helpful strategies and eventually become a handicap. We, like many mammals, are social beings. Our survival as a species depends on keeping the group together. In pack animals, the alpha male must be vigilant for transgressions against his authority and is constantly tested. In humans, unlike our mammalian cousins, guarding the social fabric becomes an internalized function. We put pressure on ourselves to do what is right for the group instead of relying entirely on the leader for discipline. But we don't start out that way.

Dog owners (alphas in their own right) must watch to make sure their dog doesn't take over and misbehave. Fortunately, dogs are quite sensitive to discipline so providing it is not too burdensome. Parenting a 2-year-old is similar but much more

taxing. Two-year-olds do not yet possess self-control and require constant supervision. Fear of consequences such as a reprimand from a parent is not strong enough to stop a curious toddler. Furthermore, human development is prolonged such that providing constant discipline would make parents' lives impossible. The pack animal system of control from outside would not work for us.

Instead, humans internalize a set of values. By age three, they want to be "good." Children work at incorporating values such as self-control that will stay with them for a lifetime. In addition, this system of internal values has a built-in enforcement function. When we follow our values, we feel pride. When we fail to do so, we feel shame or guilt. These powerful emotions provide reinforcement for good behavior. Each person's values reflect the generally accepted values of the family and culture, along with values specifically tailored and internalized to solve individual problems like Jack's. In this way, humans' internal controls are designed to maximize group cohesion while attending to individual survival.

Jack has internalized the value of self-sufficiency. As a child, this was particularly helpful for him. Shame prevented him from asking for attention and shielded him from repeated painful experiences of being rejected. Valuing self-sufficiency helped him develop skills in managing for himself without help. The problem is that, as an adult, Jack's emphasis on self-sufficiency goes too far and has become dysfunctional. He has trouble accepting help from anyone, including his therapist. Later in a joint session, his wife, Jane, complains that he is distant and controlling as he tries to do everything for himself. This detracts from their life together. She tries to be positive but suffers as a result of his not seeming to need her.

To summarize, we can formulate Jack's personality module as follows: Jack, as a child, experienced pain whenever he asked for attention. Early in life, to keep himself from being tempted to ask, his mind internalized the value of needing no one. His internalized value system makes use of shame to prevent him from placing himself in what was then a very painful situation. This strategy is protective throughout childhood but becomes partially dysfunctional as he enters adulthood, as it blocks him from a healthy dependence on others.

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## 2.4 Dealing with Jack's Reluctance

It would be more natural to start by addressing Jack's panic, but if he is to accept treatment we will first have to work with the resistance to treatment that comes from his shame about dependence. Our choice of approach is immediately influenced by his personality module. Could there be a way to get around his discomfort with accepting help? One approach would be to bypass his reluctance by inviting him to depend on a medication instead. For some patients, dependency can be disguised by framing it as a "required medical treatment." This approach is not the best one because it involves distancing from feelings rather than learning to cope with them. Nor would Jack accept it, given his attitude about his sister's dependency on sedatives and his father's tendency to drink too much (alcohol has the same mechanism of action as sedative medications). Let's look for a better solution.

A second approach to Jack's personality module can be incorporated into standard *cognitive-behavioral treatment (CBT)* for panic. We could describe psychological treatment not as dependence but as a technical intervention in which he will strengthen his self-sufficiency by learning new ways to deal with a challenge. By framing the treatment as helping him build positive strength, we might bypass Jack's value system and feelings of shame.

Ideally, we would like to modify Jack's insistence on self-sufficiency. Unfortunately, at this point, questioning his values would be much too threatening. How could we question the source of his greatest pride? With a therapeutic alliance that is already shaky, he would almost certainly feel offended and might run from treatment. We will need to accept the short-term advantages of the CBT strategy to work around his values. While necessary, given the present situation, this strategy will not help with more long-term problems like his marriage. Hopefully later we may be able to address his personality module in a more direct way.

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## 2.5 Jack's Panic Attack

Now let's turn to the other module, Jack's Panic attack. So far, we have a hypothesis to explain Jack's reluctance to depend on therapy, but we have yet to form one about the forces behind his panic. An experienced therapist will be aware that failure to address the stresses causing his panic may lead to false optimism about treatment. It is likely that Jack will not be as easy to treat as it might appear. Unless we address the issues causing his panic, he may have trouble successfully implementing skills for coping with panic, or his panic attacks may be more resistant to treatment than expected.

Looking at Jack's symptom of panic, some individuals are genetically more prone to anxiety than others. But that still doesn't tell us why Jack developed panic at this point in his life. We can start with the hypothesis that, in his brain, something triggered a massive alarm reaction. His brain, outside of consciousness, detected some circumstance it identified as potentially dangerous. Being highly adapted to anticipate danger, his mammalian brain then sent a strong warning signal that something was amiss and needed to be addressed immediately. Warning signals like this start in a brain structure called the amygdala, which serves as a danger detector. From there, the alarm sets off both subjective terror and an outpouring of adrenalin into his bloodstream. Adrenalin causes his heart to pound and further amplifies the feeling of something terrible happening.

What could the trigger be? Research tells us that good news can be as stressful as bad news [2]. Jack's learning of a second child and his promotion could be important sources of stress. His value system does not allow him to depend on others, so he has to handle any stress entirely on his own. For this reason, he functions like a dam holding back rising water. As the level goes up, he shows no indication of trouble until the water reaches the top, and then it suddenly spills over. His brain, aware that he has run out of options, reacts to the threat of being overwhelmed by sending out a powerful alarm. What, exactly, is the stress? Jack puts a high value on

being a good husband and provider. Between the added responsibility of his new promotion and having a second child, his brain, rightly, anticipates a major increase in demands with no increase in his already stretched ability to handle them. Of course Jack would never acknowledge that he was near his limit, so he has no awareness that trouble is near. In dramatic fashion, the water gushes over the dam.

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## 2.6 Asking Why

Why do we have to guess at what is going on in Jack's mind? The problem is that a substantial portion [1] of mental processing goes on outside of consciousness. Certainty about Jack's inner processes would be highly desirable but is simply not possible. Watson, the founder of behaviorism, felt that, lacking the certainty of observable facts, why questions should not be asked, but we will see that asking and forming an educated hypothesis have important advantages. Fortunately, the impossibility of direct observation is not as big a problem as it might seem.

Therapists are a little like the hunters and trappers of centuries ago. By listening and learning, over time, we develop skill and confidence in our ability to make predictions based on subtle clues. Some of our ideas resonate with patients, while others do not, and the ones that do tend to lead to therapeutic change. Even without observing the inner workings of the mind, consistently building hypotheses and testing patients' reactions build our own pattern-recognizing ability. Our sense of assurance increases as we gain wider experience.

With what we know so far, we can say that Jack is experiencing increased responsibility, which is much more stressful than it should be because his value system does not allow him to reach out for support. Already near his breaking point, he is caught between life circumstances and his personality. Something has to give, and his brain is signaling the emergency.

Thus, forming ideas about why gives us a much broader picture of what is happening in Jack's mind. If the hypothesis is not entirely correct, it can be rethought as we go forward. For now, having a coherent picture of the complex causes of his panic attack gives us a clear advantage in understanding his reactions and planning his treatment.

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## 2.7 A Third Module

Looking at Jack's life historically, there is a third and even deeper module of pathology. At the bottom of the layers, Jack is actually a survivor of a degree of emotional neglect. Healthy feelings of pain, anger, and grief should be normal for a child who had to grow up too fast. He has carried those painful feelings silently, held in check by a value system that emphasizes toughness. If we ask him how much he suffered as a young child, he will make light of his experience and tell us that his early life was like any other. His values block him from feeling any kind of self-compassion or grief for the childhood he missed. As a result, he has no conscious awareness of

those feelings or of the relief he might gain from being able to revisit and heal them with his therapist. Let's explore this third and deepest module.

Pain and other negative feelings are part of life. They are inevitable but need to follow a natural cycle to be metabolized. From the earliest age, the cycle is repeated. Small children cry when they feel distress. Soon they learn to be soothed by the understanding of a parent or caregiver. With a reassuring look they quickly feel better and go back to playing until the next painful event. Even as adults we continue to make use of this cycle. When we experience negative feelings, sharing with someone who understands and is not overwhelmed makes us feel much better even if the painful condition has not changed. We go back to our baseline without carrying a lasting residue. This is what is meant by "metabolizing" an emotion.

On the other hand, when the cycle is blocked, the result is lasting. Painful feelings that are held in mid-cycle are kept outside of consciousness though they can cause breakthrough symptoms like tears or anger for no apparent reason. In Jack's case, his value system has done such an effective job of shielding him from his own feelings that they are essentially inaccessible. Feelings blocked so completely have no direct effects but important indirect ones. One result is his lack of compassion for himself and for others, like his wife. Another is that the presence of such deep, unresolved feelings increases his need for support and undermines his resilience. This actually increases his vulnerability to the panic attack.

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## 2.8 A More Complete Picture

Now we have a full picture of Jack's problems. They can be described as consisting of three modules of pathology with one stacked on top of another. The deepest layer is unmetabolized pain from early deprivation. Painful emotions are held in suspension. The deepest dysfunctional pattern was suppression of these feelings, an arrest of the normal cycle of expressing affect and experiencing the healing effect of sharing. When this layer of feeling suppression threatened to fail, his mind anticipated tears and anger escaping into consciousness where they would lead to a painful scolding. That, in turn, triggered development of the next layer.

The next layer, his personality and value system, developed early in his life to keep him from expressing the pain of his emotional deprivation. His mind internalized a value system favoring self-sufficiency, now deeply incorporated in his personality. While this blockage keeps his feelings at bay, it creates a rigidity that causes him to be less resilient than someone who could accept support and help. This is the dysfunctional aspect of his value system. In effect, his personality is the source of a new vulnerability. Under the pressure of new responsibilities, his mind anticipates failure of his ability to cope. Jack is threatened with being overwhelmed by feelings of helplessness so powerful that they could overcome even his strong sense of shame and enter consciousness.

To protect him from awareness of these natural and healthy emotions, his brain produces a third module, the panic attack, stacked on top of the other two. This symptom actually succeeds in shielding him from being overwhelmed because it

forces him to seek medical help, giving him temporary relief from responsibility and access to the support he could not otherwise allow himself.

Each module functions to block a painful or overwhelming feeling. When an earlier one shows signs of failing, the mind anticipates the conscious experience of a painful feeling. A new layer is placed on top of previous ones to block feelings that threaten to escape. While Jack's three modules of pathology seem completely different from one another, they have a common function and, as we will see, many common features.

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## 2.9 The Basic Unit of Pathology

One of the major ways this book is different from others is dividing problems into modules. Traditionally, mental pathology is categorized by diagnosis. The problem is that, as in Jack's case, no one diagnosis can really capture his interlocking problems. Multiple diagnoses are possible, but they don't give any understanding of how one problem relates to the others. Another approach used in teaching psychotherapy is to divide problems into dimensions such as personality, acute symptoms, relational style, etc. This adds complexity in that we have to look at each patient from several different perspectives at once. It can also miss important relationships between modules. Dividing Jack's pathology into modules not only simplifies our understanding, but each module can be seen as a distinct embodiment of the same natural drive to avoid painful feelings.

For purposes of this text, we will use a new term, *entrenched dysfunctional patterns (EDP)*, to refer to modules or units of pathology. All of the mental pathology that can be helped by psychotherapy can be divided into EDPs. Why use this phrase? The pathology patients seek to change is always *entrenched*, in that it is resistant to change. If it weren't, then professional help would not be needed. These units are necessarily *dysfunctional*, meaning that in some way they detract from the life the patient would like to live. And finally, they can all be seen as *patterns*, that is, units that can be described in words and are likely to be repeated.

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## 2.10 Advantages of the EDP Concept

The real beauty of identifying pathology as made up of entrenched dysfunctional patterns is that each one has the same internal structure. Each one starts with the mind's recognition of a circumstance that threatens to bring up an intensely uncomfortable feeling. Let's review Jack's EDPs from the newest to the oldest, that is, from the top layer to the bottom. The most recent, Jack's panic attack, started with nonconscious perception that his new responsibilities could soon overwhelm his ability to handle added stress on his own. Underneath that, his dysfunctional value system was created long ago to shield him from seeking attention when it was not available. And, at the bottom of it all, stopping the natural cycle of distress and healing was simple suppression of feelings he dared not share. Each of Jack's three EDP



layers is the same in that some perceived circumstance, internal or external, triggered the anticipation of a painful, overwhelming or uncomfortable feeling, which then led to development of an avoidance mechanism. Once formed, these entrenched dysfunctional patterns are not forgotten but remain available whenever a threat is detected.

Besides highlighting the common structure of the psychopathology we seek to treat, perhaps the most important advantage of the EDP concept is that it shows the relationship between emotion and behavior. This is of key importance because some therapies put more emphasis on thought and behavior, while others favor work with emotion. The EDP concept shows emotion and behavior as different components of the same unit. From a practical standpoint, each EDP can be approached therapeutically from either or both sides. One approach is to detoxify the feeling, and the other is to substitute a healthier pattern of thought or behavior. In fact, these two pathways represent the two basic actions of psychotherapy, healing emotions and changing patterns of thought and behavior.

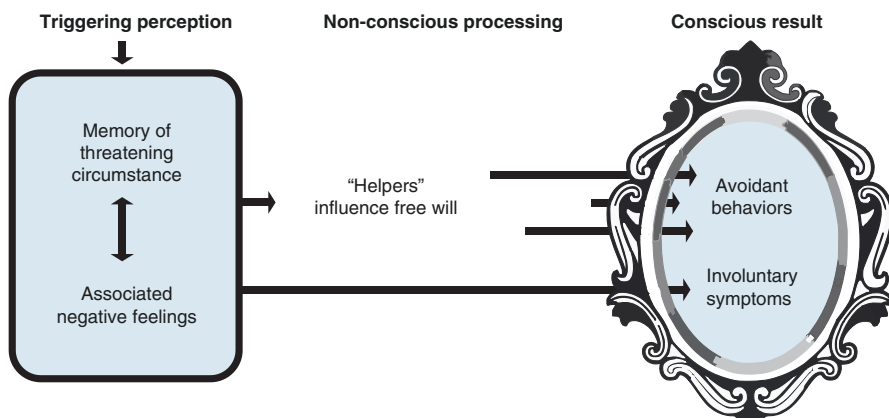
To be more precise, healing painful feelings breaks the link between a perceived circumstance and the perception of danger. How do we do this? As we will see in the following chapters, healing emotions is primarily accomplished by helping patients actually experience the feeling in a context of empathic connection and safety. As feelings are detoxified or, to use a different term, metabolized, the patient will no longer feel threatened by a circumstance that was previously a source of dread. Here, as emphasized in trauma- and emotion-focused therapies, the object is to take the drive out from under the avoidant behavior or symptom. Alternatively, helping patients let go of and replace dysfunctional patterns is another way to improve functioning. Changing dysfunctional thoughts and behavior is a specialty of CBT, among other therapies.

Much of the time, work on one aspect exposes the need for work on the other. Processing feelings makes it possible to address problematic behaviors, while improvements in behavior often unmask difficult feelings. Thus, two seemingly opposing worlds of psychotherapy can be seen as alternative ways to approach the same EDP.

Below let's preview a diagram that helps visualize the common structure of all entrenched dysfunctional patterns (Fig. 2.1). On the left, each one starts with some perception, internal or external, that is recognized as a possible source of danger or threat. Next the nonconscious mind goes to work and produces some combination of the following three kinds of avoidance mechanism, which then enter consciousness and may lead to seeking professional help:

- Potential behaviors designed to distance from threatening feelings pop into the conscious mind, where we have a free choice of whether to implement them or not.
- Helpers are positive and negative feelings, impulses, special feelings of pride, shame, and guilt, and automatic thoughts. These enter consciousness to influence free will to put avoidant behavior strategies into action.
- Involuntary symptoms such as anxiety and depression that have biological roots but also function to distance from threatening feelings.





**Fig. 2.1** Diagram of entrenched dysfunctional pattern

Each of these avoidance mechanisms enters consciousness where the resulting pain and dysfunction may cause us to seek professional help. The details of the diagram will be explained further in the next chapter.

## 2.11 Resisting Positive Change

*Entrenched* means resistant to change. In general, when therapy encourages us to let go of a once protective pattern, our mind anticipates that removing a protection could put us in danger of experiencing a painful affect. In this way, change itself triggers anticipation of uncomfortable affects. Naturally, then, our nonconscious problem-solving mind goes to work to steer us in the opposite direction, that is, further away from healthy change. This avoidance of change is recognized in all therapies as “resistance,” meaning a nonvoluntary reluctance to experience uncomfortable feelings or to implement new patterns of thought or behavior.

The mind approaches the “danger” of healthy change by inventing or using what is, in effect, a new entrenched dysfunctional pattern, a new layer of avoidance. For example, this might be a rationalization to convince the self and the therapist that change would not be a good idea. In Jack’s case, the idea of limiting therapy to a single session is one of these.

What makes these avoidant maneuvers EDPs? They have the same structure as other EDPs. They are triggered by anticipated negative feelings and consist of patterns of avoidance that are dysfunctional in that they block progress in therapy. As we identify these new EDPs, we can approach them therapeutically the same way we approach other EDPs.

It is important to note that resistance, in spite of its negative connotation, is automatic and not willful. The word “resistance” is frequently misunderstood by patients as an accusation and should almost never be used with them. It is also

important to note that what looks to the therapist like resistance may be the result of a therapeutic error or confusion about the process rather than discomfort with healthy change.

Despite these potential misunderstandings, it is extremely useful to be able to conceptualize resistance to change as a natural reaction to therapy and as one more form of entrenched dysfunction pattern. Jack's statement that he expects to terminate therapy after one session can be seen more completely as an EDP triggered by anticipation of the shame he would experience if he were to give in to the temptation to seek help.

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## 2.12 A Fresh Approach to Jack's Treatment

Armed with an understanding of Jack's stacked EDP layers, we now have a firmer grip on how to plan his treatment. We will start with the EDP that stands to block treatment in the first place, that is, his reluctance to accept therapy. Since changing his value system is a long-term process, and he is in crisis, we will need to adopt a superficial approach to the personality layer at this time. The best way to do this is, in fact, to introduce CBT not as a support but as a technical "procedure" to help him manage the panic. This less threatening way of presenting treatment will also give reassurance that his physical health is okay and that panic is a natural reaction that can be managed. This is likely to be sufficiently nonthreatening to avoid his shame and allow him to agree to a few sessions.

As CBT treatment gives him some sense of mastery of his panic, we will need to address that EDP's emotional driver. CBT sessions and the attention they embody will satisfy some of the need for support that he can't acknowledge. Education about the stress of a second child and a new level of responsibility at the job will help him begin to acknowledge a bit of neediness. This sharing of feeling will reduce the emotional pressure behind his panic. If needed we can also consider recommending a few days off work or adding medication, despite its disadvantages, to further reduce the threat of his being overwhelmed by feelings of panic.

Making use of the crisis as justification, we can encourage participation by Jack's wife in his care. This will legitimize support from her and will also give her a chance to begin to voice her frustration about his difficulty accepting her help. As he experiences some success in managing the panic, raising his consciousness about his unhealthy fear of dependence could lead to work with the personality EDP. Motivated by a desire to be a good husband, he will need education and more long-term work to understand healthy dependency and to process the shame associated with acknowledging human needs. In the distant future, as he becomes more accepting of his own feelings and needs, his frozen feelings of hurt and anger may become accessible. Emotion-oriented treatment will require that these feelings be brought into the room so they can be healed through an empathic and safe therapist–patient relationship.

We will review how to build a treatment plan in general in Chap. 9.

## 2.13 Integrated, Modular Treatment

By bringing into one frame, feelings, thoughts, and behavior, the entrenched dysfunctional pattern concept shows how seemingly contrasting therapies are actually different ways to work with the same units of pathology. Therapies focused on emotion work from one direction, while therapies that emphasize thought and behavior work from the other. Thus, most contemporary treatment orientations can be brought under the same roof, where we can take advantage of the wisdom each has to offer.

In this way, instead of the more traditional method, learning a single brand of therapy and then assimilating additional techniques, we can learn a more universal approach from the beginning. The conceptual framework presented in this book is a form of *psychotherapy integration*, that is, the coherent mixing of techniques from different traditions. The choice of what method to use depends more on the specific change process we are seeking to accomplish rather than to what tradition it might belong. In general we will be seeking either to process emotions or to replace the dysfunctional patterns of thought and behavior embodied in a particular EDP.

*Modular therapy*, discussed in greater depth in the next chapter, means choosing the technique that is best suited to the particular problem being confronted rather than using a single approach for all aspects of a case. By dividing mental pathology into EDP modules, we can plan our approach more precisely and, for each one, use techniques that are chosen to be comfortable to the patient, familiar to the therapist, and effective for the task at hand.

### Key Points

- Each patient's problems can be divided up into distinct modules called entrenched dysfunctional patterns or EDPs.
- All EDPs are triggered by the anticipation of experiencing a painful, overwhelming, or uncomfortable emotion and consist of a pattern of thoughts, feelings, and behaviors designed to avoid the dreaded emotion.
- Any EDP can be visualized as unit with the triggering circumstance and its associated feeling on one side and the pattern of avoidance on the other. In between is the invisible mental processing that creates and implements an avoidance strategy.
- Multiple EDPs can be visualized as stacked in layers starting with the earliest at the bottom. Emotions anticipated to escape from one layer are what trigger the next.
- For a given EDP, psychotherapy can approach by detoxifying the triggering feeling or by helping the patient change thoughts and behaviors.
- Integrated, modular therapy is usually targeted at the most accessible EDP. It can approach via the emotion or via the avoidant thoughts and behaviors and can be chosen for the precise job at hand.

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